

THE TOTAL ENCOUNTER CAPSULE*

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For the last nine years, on a regular basis, groups of naked mental patients have been locked in a small room for periods ranging up to eleven days. In order to make the Total Encounter Capsule seem, if not a useful form of therapy, at least logical and not perverse, there is a need to provide some background information about this particular hospital, its patients and its programs.

The maximum security division (Oak Ridge) of the Mental Health Centre at Penetanguishene receives patients from the courts, penitentiaries, reformatories, jails, and psychiatric centres throughout the Province of Ontario. Three hundred hospital beds were provided to manage patients who cannot be safely treated elsewhere because of the seriousness of their legal situation or the presumed dangerousness of their psychiatric state.

In 1965 we began to develop intensive methods of group therapy which made maximum use of the resources of patients alone; programs which rested in part on the assumption that a genuine encounter between persons, in the terms of Martin Buber's "Turning Towards", was the aim and achievement of therapy. In Buber's words: "the basic movement of the life of

dialogue is the turning towards the other . . . genuine dialogue — no matter whether spoken or silent — where each of the participants really has in mind the other or others in their present and particular beings, and turns to them with the intention of establishing a living mutual relation between himself and them" (4).

Development of patient run treatment programs was possible for three main reasons. First, most of the one hundred and fifty patients confined in the four milieu therapy wards possessed relatively intact personalities (not grossly psychotic or severely retarded); secondly, their length of stay was usually measured in years; and finally there had always been a low patient/professional staff ratio — never less than thirty to one. If a patient wanted to change, he could see that there were never enough psychiatrists, social workers or psychologists to try to give him much direct help.

The intensity of the original programs gradually escalated during 1966 and 1967 to the point where the patients on the most intensive treatment ward were participating in one hundred hours per week of structured interaction in a community whose emotional climate was frequently fueled with a battery of so-called defence disrupting drugs — Sodium Amytal, Amphetamines, Scopolamine, Dexamyil-Tofranil and LSD (3, 8). Such disruption of deeply entrenched defences made good sense for patients in Oak Ridge, where anything short of a major

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personality alteration might well mean lifelong incarceration.

By late 1967, it became clear that two main problems dictated the need for further changes in the programs that had developed. In the first place, although anxiety raising procedures may be good treatment from the point of view of personality change, the risks of homicide and suicide become very real in such programs. And this is especially so in a conventional hospital ward where patients have relatively easy access to steel bed-springs, sheets, chairs, forks, and spoons — a veritable armoury for anyone eager to act out on himself or someone else. As the level of anxiety continued to escalate in the programs, it became more and more likely that the elaborate system of safeguards and observers might fail (7).

The other problem was the phenomenon of patients, usually psychopaths, rising to the organizational apex of a therapeutic community without themselves being touched by the program. Glib, articulate, and well versed in the defensive "psychologese" that can cover the most radical conflicts by describing them impressively, they had become accustomed to operating with a minimum of discomfort in the highly structured programs. Intellectually, however, many of these patients had learned that they were indeed sick, and that the way out was to get well. It was these patients who were keen to team up with professional staff to make use of any resource possible to solve their dilemma. It was these patients who admitted that as long as they could retreat to the privacy of their own room at night, or escape with television or books, that even a one hundred hour a week program would still leave them unscathed. It was these patients who realized that a confrontation would be inescapably intense if each was in the physical presence of all the others continuously, for long periods of time. In part we were influenced by the work of George Bach who conceptualizes the Marathon therapeutic process as "a practicum in authentic communication, based on freedom from social fears conventionally as-

sociated with transparency" (1).

In October 1967, therefore, the Sunroom program was started with the purpose of involving volunteer patients, who had been relatively untouched by other forms of therapy, in a program that also provided increased safeguards against homicide and suicide. After eight months' experience with the operation of the Sunroom program (5), the Total Encounter Capsule was designed. It was to function as a place of undisturbed security where a small group of voluntary patients could focus upon issues they felt important enough to warrant the exclusion of the usual physical and psychological distractions, and the possible risks of suicide or homicide that might attend extremely intense personal encounters.

The Capsule is a specially constructed, soundproof, windowless, but continuously lighted and ventilated room, eight feet by ten feet, with a soft rug-over-foam floor, which provides the basic essentials — liquid food dispensers, washing and toilet facilities — and in which it is possible for a group of up to seven patients to live for many days at a time, totally removed from contact with the outside. The Capsule group is under constant observation, either through a one-way mirror in the ceiling and/or by closed circuit television, and a high quality audio amplifying system. Patient observers, trained specifically for this full-time job, work eight hour shifts, and have a wide variety of duties. They must keep a continuous supply of liquid food — soups, milkshakes, tea, coffee, cocoa — available to the group, regulate the temperature of the Capsule to comfortable levels at all times, record on video tape any interaction that is deemed significant enough to replay for the participants or staff, keep a continuous written record of events as they unfold, and intervene if it appears that physical acting out is imminent.

It was decided, as the ground rules for the first groups were being drawn up, that the patients would participate in the Capsule without clothes. This move was prompted partly by the experience of Paul Bindrim, a

psychologist working in California, who felt that the uncovering of the private parts of one's body might facilitate the uncovering of the private parts of one's mind, and partly because of our fear that clothing might be used in a dangerous manner.

It is hard to recapture, after nine years' experience, the initial excitement and anxiety of staff and patients alike who together planned and built the Capsule. The flavour of some of this thinking is reflected in an early consent form which asked among other things: why are you volunteering? are you under pressure from your ward to do so? what rewards or penalties do you see as a result of volunteering? and, are you willing to have the staff use tear gas "if an emergency arises"? There was much concern regarding suicide and homicide precautions, perhaps understandable considering everyone's inexperience with such an intense setting, coupled with the fact that all the patients had previously killed one or more people or had otherwise been associated with sufficient violence to earn their way into a maximum security mental hospital. There was considerable discussion over the use of tear gas to abort violence. In fact, the only time tear gas has ever been used in the Capsule was during a trial run with two patients who volunteered to try to sustain a strangle hold for thirty seconds after having been sprayed with two competing brands of tear gas! Moreover, instances of even minor physical acting out have been noteworthy for their rarity.

During the first six months of operation of the Capsule forty-seven patients participated in seventeen groups which ranged in size from two to seven patients (average four) and in duration from one to eleven days (average four). The patients ranged in age from fifteen to thirty-three years (average twenty-two) and in education, from Grade 3 to three years of university (average Grade 8). Eleven of the forty-seven participated in two different groups, and six in more than three groups. Two-thirds of the participants expressed a definite desire to re-enter the Capsule, 27 percent said they would definitely not want to return, and 7 percent were undecided.

Ten percent felt the experience was of no particular value and 90 percent felt it was helpful and useful, saying such things as: "have come to have respect for others' feelings", "came to a closer awareness of my problems and the ways I keep people at a distance", and "learned more about how I affect people".

Included in the seventh group held in the Capsule was a reporter from a large daily newspaper, who had been invited by the hospital to do a story about the Capsule because of a fear that a less informed and more sensational press could distort its function and purpose sufficiently to force its closure (9, 12).

Over the years the Capsule has been used in a great variety of ways, usually with the basic objective of providing a treatment situation in which the patients could help each other to acquire an improved accuracy of perception of their own and others' feelings and ways of relating, where the direction and intervention of trained professional staff was at a minimum. The challenge was to prevent the group from falling into any of the many snares and pitfalls which commonly beset the life of a therapy group as the members move towards a deeper level of mutual trust and acceptance (2). In many of the groups, one or more patients are given one of the defence disrupting drugs. Frequently, prospective group members have been required to study and write examinations on material relating to feedback and role functions in groups. "Traditional psychoanalytic theory concerns itself mainly with internal conflicts of which the patient is unaware. The [human relations training] laboratory is concerned with conflicts arising out of a limited awareness of social relationships. Ineffective social behaviour can persist because the individual is unaware of its consequences. The laboratory creates opportunities to become aware of the effects of behaviour upon others by explicitly promoting an atmosphere of frankness" (11). The groups have often negotiated a specific "contract" with the staff regarding the frequency of coming out of the Capsule for solid meals or showers, and the method

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of deciding when the group would disband. In general, our experience has shown that groups with a predetermined time for release from the Capsule tend to "coast". Frequently music has been piped into the Capsule as a diversion. For awhile a light plastic ball was used by the groups, but later rejected. There was an attempt to utilize two groups at the same time, one housed with a television monitor in the Sunroom next to the Capsule, while the other was in the Capsule, and then trading places every other day — each group thus being exposed to detailed analysis by the other. Human Development Institute encounter tapes (10) coupled with video-taped feedback of some of the sessions have been used. For a time groups used the Capsule wearing some clothing, but this was later rejected in favour of the earlier practice of nudity. Some groups were created so that especially skilled and experienced patients could intensively interact with an acute psychotic patient so that he could be managed without drugs or ECT. For a time an elaborate system of coloured lights was installed to signal the group to begin "mirror" groups. (The mirror group is a type of round robin procedure frequently used in the hospital in which each member, in turn, gives his opinion of himself with regard to a specific question and then comments on his perception of each of the other members of his group in relation to the same issue). Each "mirror" consisted of a printed list of questions, covering one of four possible areas of concern — personal feelings, role functions, feedback, and group con-

tinuance. Since the Capsule first became operational in August 1968, it has been the preferred place for the administration of LSD — a relatively peaceful environment in contrast to the noisiness of the pervasive prison steel and terrazzo architecture — where the unobtrusive and high quality audio amplifying system and closed circuit television are an asset.

Attempts to evaluate the effectiveness of the Capsule as a form of treatment are complicated by two things. The manner of its operation has continued to evolve and change over the years, reflecting the interests of professional staff and patients present at any one time. It seems too high a price to pay to fix a rigid format on so flexible a treatment facility in order to assist research. Secondly, patients participating in Capsule groups do so only for relatively brief periods of time, then are once again immersed in the intensive milieu therapy programs functioning on the Social Therapy Unit. To isolate the effects of the Capsule from the effects of these other programs would be difficult. A research project evaluating a program with the same basic objectives as the Capsule — a situation in which the participants could help each other to acquire an improved accuracy of perception of their own and others' feelings and ways of relating, where the direction and intervention of trained professional staff was at a minimum — has been completed. Participants in this program did show significant changes one year later as compared to randomly-assigned control groups (6).

The Capsule program† has not eliminated the problem of the escapist role-playing of the articulate psychopath, although it has helped. Its main contribution has been rather to provide a brief, very intense, but safe experience for a patient to look forward to or back upon as a bench mark during a lengthy stay in hospital. If nothing else, the Total Encounter Capsule has stood the test of time in serving this important function.

Summary

For the last nine years, groups of patient volunteers in the Social Therapy Unit of the

†It is of some importance to point out that the Capsule program was initiated and is still successfully operating in what to many is assumed to be the stultifying environment of a bureaucratically run government institution. While this is mostly a tribute to the administrative competence and bold concern for patients embodied in the then superintendent, B. A. Boyd, it is also a reflection of the higher government administrators and the politicians so often assumed to be too fearful of criticism to permit innovation. In this same context we are indebted to the Donner Canadian Foundation for generous financial support of this project.

maximum security section of the Mental Health Centre at Penetanguishene have been making regular use of the Total Encounter Capsule. The Capsule is a specially constructed, soundproof, windowless, but continuously lighted and ventilated room, eight feet by ten feet, which provides the basic essentials — liquid food dispensers, washing and toilet facilities — and in which it is possible for a group of up to seven patients to live for many days at a time, totally removed from contact with the outside. It functions as a place of undisturbed security where a small group of voluntary patients can focus upon issues they feel important enough to warrant the exclusion of the usual physical and psychological distractions (including staff), in a setting where the risks of suicide or homicide that might attend extremely intense personal encounters are at a minimum. The many ways in which groups of patients have used this facility are reviewed and the problems of researching the effectiveness of the program are discussed.

Included in the paper is an overview of the historical development of all the intensive coercive milieu therapy programs at Penetanguishene so that the purpose and function of the Capsule can be seen in context.

Designed initially as an attempt to overcome the problem of the escapist role-playing of the articulate psychopath, the greatest value of the Capsule is now seen more importantly as the way in which it provides a brief, very intense, but safe experience for a patient to look forward to or back upon as a bench mark during a lengthy stay in hospital.

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Résumé

Au cours des neuf dernières années, des groupes de malades volontaires de l'Unité de Thérapie Sociale d'une section à sécurité maximum du Centre de Santé Mentale à Penetanguishene ont utilisé régulièrement une Capsule de Rencontres Totales. Cette Capsule est construite d'une façon spéciale. Elle consiste en une chambre de 8' x 10', à l'épreuve du son, sans fenêtre, mais continuellement éclairée et ventilée. Elle satisfait aux besoins fondamentaux essentiels: dispensateur de nourriture liquide, facilités de toilette et de lavage. Il est donc possible pour un groupe pouvant atteindre 7 malades, d'y vivre pour plusieurs jours complètement isolés des contacts extérieurs. La Capsule représente un lieu de sécurité non troublé où un petit groupe de malades volontaires peut se concentrer sur des problèmes qu'il croit suffisamment importants pour se détacher des distractions physiques et psychologiques habituelles (incluant le personnel) dans un

lieu où sont réduits au minimum les risques de suicide ou d'homicide pouvant survenir dans des rencontres personnelles extrêmement intenses. On passe en revue les différentes façons dont la Capsule a été utilisée par divers groupes de malade et on discute du problème de l'étude de l'efficacité de ce programme.

On fait un bref résumé du développement historique de tous les programmes de thérapie dans un milieu coercitif intensif à Penetanguishene de sorte que le but et la

fonction de la Capsule puissent être replacés dans ce contexte.

La Capsule avait été initialement conçue comme une tentative de solutionner le problème du rôle de retrait joué par le psychopathe habile à manipuler les mots. Toutefois, on constate maintenant que sa plus grande valeur est maintenant de fournir une expérience brève, très intense, mais sécuritaire pour un malade désirant un refuge qu'il peut utiliser durant un séjour prolongé à l'hôpital.
